MONROE COUNTY, NEW YORK

2016-2018 COMMUNITY HEALTH IMPROVEMENT PLAN

Monroe County Joint Community Service Plan
2016-2018

For Health Systems Serving Monroe County, including:

ROCHESTER REGIONAL HEALTH

- **Rochester General Hospital**
- **Unity Hospital**

UR MEDICINE

- **Strong Memorial Hospital**
- **Highland Hospital**

Monroe County
Department of Public Health

With collaboration from

- **Center for Community Health, UR Medicine**
- **Finger Lakes Health System Agency**
- **Finger Lakes Performing Provider System**

Monroe County Community Health Improvement Plan (MC-CHIP) 2016-2018

County Name:	Monroe County
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Executive Summary

Rochester, NY and its surrounding communities in the Western New York Region have a long history of collaboration to improve the health of the Monroe County residents. Hospital systems in Monroe County including; Strong Memorial Hospital and Highland Hospital, both of University of Rochester Medical Center and Rochester General Hospital and Unity Hospital, both of Rochester Regional Health, have jointly filed a community service plan to the New York State Department of Health for the past fourteen years, and this year is no exception. This unique effort, done in collaboration with the Monroe County Department of Public Health (MCDPH) and the Finger Lakes Health System Agency (FLHSA), demonstrates true community health assessment and improvement planning. This partnership assures synergistic, non-duplicative meaningful strategic efforts towards the common goal of improving the population's health.

The 2016-2018 Monroe County Community Health Improvement Plan (MC-CHIP) was collectively created based in the collaborative Community Health Needs Assessment that was developed jointly between the organizations listed above in-combination with consideration for the input of Monroe County residents. All hospitals and the MCDPH will address four Prevention Agenda Priories for which the details are outlined below.

1. Prevention Agenda Priorities

Working collaboratively through the Community Health Improvement Workgroup (CHIW), which includes the hospitals, local health department and community partners including FLHSA and FLPPS, the following priority areas were selected from the Prevention Agenda for the 2016-2018 period:

1. **Prevent Chronic Disease: Smoking Cessation**
   Reduce Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
2. **Prevent Chronic Disease: Heart Health Management and Prevention**
   Increase Access to Quality Chronic Disease Prevention and Management in Clinical and Community Settings
3. **Promote Healthy Women, Infants and Children: Reduce Unplanned Pregnancy**
   Reproductive, Preconception and Inter-Conception Health
4. **Promote Healthy Women, Infants and Children: Screen for Food Insecurity**
   Child Health
5. **Promote Mental Health and Prevent Substance Abuse: Opioid Misuse Prevention**
   Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Disparities exist within each of the priority areas based on race, and also on socioeconomic status. Specifically, three of the objectives identified in the CHIP call for action aimed at disparate populations:

Objective 1.3: By December 2018, decrease the percent of women who smoke during pregnancy from 11% of births (2013 vital statistics) to less than 10% of births, and to especially concentrate on those women who receive Medicaid – baseline 20% of births were smoking during pregnancy.

Objective 2.1: By December 2018, decrease the disparity among hypertensive residents in the local registry who have their blood pressure in control by increasing the control rate

among Monroe County African Americans [58.8% and Latinos (61.5%) compared to Whites (75.4%)]

Focus area 4: screening for food insecurities will address social needs among those who are in lower economic brackets.

2. Emerging Issues and Continuing Projects

Some of the focus areas from the 2014-2016 CHIP will continue in the 2016-2018 plan.

- Monroe County will continue to focus on linking each hospital to the NYS Quitline allowing for an electronic transfer of patient data to replace a hand-written referral. Several local hospitals have already passed a policy to support this goal, and others are working on EMR changes to facilitate this initiative. The MC-CHIP will monitor progress on this focus area in the coming years.
- Monroe County has a very robust High Blood Pressure Collaborative that is community driven and includes business leaders as well as the hospital. The MC-CHIP 2016-2018 will continue to focus in this area and will work with the High Blood Pressure Collaborative as much as possible to decrease the rate of hypertensive patients who have blood pressure out of control.

Since submitting the 2014-2016 Community Health Improvement Plan, new and emerging needs have been identified through the process of completing our CHNA. Specifically, the group has added components to our plan that address the following:

Promote Healthy Women, Infants and Children:

- Reduce Unplanned Pregnancy (Reproductive, Preconception, and Inter-Conception Health) – Our review of the Monroe County data found that the unplanned pregnancy rate among adults in Monroe County is higher than NYS as a whole; and that disparities exist among Blacks, Latinos, and Medicaid Enrollees.

Promote Healthy Women, Infants and Children

- Screen for Food Insecurity (Child Health) – In preparing the CHNA, it was discovered that 23% of Monroe County adults report food insecurity and 20.5% of children live within food insecure households. Since the 2014-2016 CHIP, the American Academy of Pediatrics has recommended screenings for social determinants of health including food insecurity. And since the last report, the Rochester Monroe County Anti-Poverty Initiative (RMAPI) has directed resources towards addressing poverty community.

Promote Mental Health and Substance Abuse:

- Promote Mental Health and Substance Abuse: Opioid Misuse Prevention (Prevent Substance Abuse and Other Mental and Emotional Behavioral Disorders) - Between 2013 and 2014, death from accidental heroin/fentanyl overdose rose 70% within Monroe County.

3. Data Review in the Community Health Needs Assessment

The CHIW examined data from a variety of sources; the details of which are explained in their entirety within the CHNA. In short, the workgroup spent a large amount of time extensively reviewing the New York State Prevention Agenda with particular interest in the county level dashboards. In addition, the workgroup also reviewed the following sources

- Mortality and natality data: New York State birth and death files
- Mortality data from the Office of the Medical Examiner, Monroe County
- Statewide Planning and Research Cooperative Systems (SPARCS) files, based on hospital discharges and emergency room visits
- Monroe County Youth Risk Behavior Survey (YRBS)
- Local Monroe County Blood Pressure Registry
- ACT Rochester
- Monroe County Adult Health Survey

To prioritize, the group looked for areas in which Monroe County was identified as worse than New York State as a whole or in which Monroe County was not previously able to meet the Prevention Agenda target. Additionally, the group looked for new or emerging troublesome health trends that may not have been identified as a Prevention Agenda Target. Additional consideration was paid to qualitative data collected via community input.

4. Partnerships

The completion of the 2016-2018 Monroe County Community Health Needs Assessment (CHNA) and the 2016-2018 Monroe County Community Health Implementation Plan (CHIP) was a collaborative effort in which the following organizations contributed; Strong Memorial Hospital and Highland Hospital, both of University of Rochester Medical Center and Rochester General Hospital and Unity Hospital, both of the Rochester Regional Health, and the Monroe County Department of Public Health (MCDPH). The two hospital systems provide financial and in-kind resources for the Community Health Improvement Workgroup (CHIW), and have supported a chair to convene the group. The team meets both monthly and bi-monthly dependent on the needs of the group and has been doing so, in this format, for over 10 years.

Each hospital system has at least one representative on the CHIW team. Additional representatives include public health experts from the following organizations; Monroe County Department of Public Heath (MCDPH), and the Finger Lakes Performing Provider System (FLPPS). Finger Lakes Health System Agency (FLHSA), another critical CHIW organization, provides insight into the needs Rochester community members. The University of Rochester Center for Community Health serves as a facilitating agency for this process.

5. Community Engagement

The community engagement process used by the Community Health Improvement Workgroup involved reviewing results from various projects that have recently gathered community input related to health issues affecting residents. The entire process including findings is detailed in the Community Health Needs Assessment document. The 90 minute CHIW meeting in February was dedicated to reviewing community input from

- DSRIP
- High Blood Pressure Collaborative Focus Groups
- Rochester-Monroe Anti-Poverty Initiative (RMAPI)

In addition, members of CHIW and their organizations provided input to our priority areas and proposed interventions via on-line survey. The needs assessment and improvement plan were shared in several community settings for input including at the Greater Rochester Chamber of Commerce Health Care Planning Team meeting and the 2015 Smoking Cessation Synergy meeting.

6. Planned Interventions and Strategies and Evaluation

All implementation strategies, interventions and measures are outlined in great detail within the 2016-2018 MC-CHIP. Interventions were only selected if they were evidence based, and most strategies were found from the Prevention Agenda's Action Plan Re-Fresh Chart (Dec. 2015). In summary:

1. **Prevent Chronic Disease: Smoking Cessation**
   Reduce Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

   Objective 1.1: By December 2018, all four hospital-based healthcare systems will enact a tobacco cessation policy that incorporates the "opt-to-quit" program and will implement that policy thereby electronically linking tobacco using patients to the NYS quit line.

   Objective 1.2: By December 2018, the Rochester Psychiatric Center will enact a tobacco cessation policy that incorporates the "opt-to-quit" program and will implement that policy electronically linking tobacco using patients to the quit line.

   Objective 1.3: By December 2018, decrease the percent of women who smoke during pregnancy from 11% of births (2013 vital statistics) to less than 10% of births, and to especially concentrate on those women who receive Medicaid – baseline 20% of births were smoking during pregnancy.

2. **Prevent Chronic Disease: Heart Health Management and Prevention**
   Increase Access to Quality Chronic Disease Prevention and Management in Clinical and Community Settings

   Objective 2.1: By December 2018, decrease the disparity among hypertensive residents in the local registry who have their blood pressure in control by increasing the control rate among Monroe County African Americans [58.8% and Latinos (61.5%) compared to Whites (75.4%)]

   Objective 2.2: Increase the control rate for hypertensive patients who also have diabetes

   Objective 2.3 (RRH ONLY): Increase the ability of patients with CHF to manage their illness

3. **Promote Healthy Women, Infants and Children: Reduce Unplanned Pregnancy**
   Reproductive, Preconception and Inter-Conception Health

   Objective 3.1: By December 2018, reduce significant barriers to the use of LARC (Long-Acting Reversible Contraception), particularly among at-risk women of reproductive age

   Objective 3.2: By December 2018, increase the number of youth reached with evidence-based sexual health education (baseline measure of current youth being reached is needed)

   Objective 3.2 (RRH ONLY): Improve prenatal care through Centering Group Prenatal Care to reduce the preterm birth rate

4. **Promote Healthy Women, Infants and Children: Screen for Food Insecurity**
   Child Health

   Objective 4.1: Decrease the percent of children living in food insecure households from 20.5% (Feeding America, 2014) while also striving to decrease the percent of adults who experienced food insecurity in the past year – worried or stressed about having enough money to buy nutritious meals (EBRFSS2013-4) from 23% in Monroe County.

5. **Promote Mental Health and Prevent Substance Abuse: Opioid Misuse Prevention**
   Objective 5.1: By December 2018, decrease the number of deaths due to opioid overdose from 69 in 2015 (Medical Examiners report of 2015).

Monroe County Community Health Improvement Plan (MC-CHIP)

During 2016, a Community Health Needs Assessment (CHNA) and Improvement Planning Process was conducted jointly by the hospital systems serving Monroe County, NY, and the Monroe County Department of Public Health with collaboration from the community planning agency, Finger Lakes Health Systems Agency (FLHSA). The hospital systems are 1. University of Rochester Medicine (URM), which is the system that includes Strong Memorial Hospital and Highland Hospital; and 2. Rochester Regional Health (RRH), which is the health system for Rochester General Hospital and Unity Hospital. All four hospitals contributed to the needs assessment which serves as the CHNA for each of the hospitals. The Monroe County CHNA is the basis of the 2016-2018 Monroe County Community Health Improvement Plan (MC-CHIP).

The Community Health Improvement Workgroup (CHIW) is committed to continuous quality improvement in community health and serves as the oversight body for the development of both the CHNA and MC-CHIP. In addition, the CHIW also champions the implementation and monitoring of the MC-CHIP. The CHIW has been meeting monthly or every other month for over 10 years. Each hospital and the Monroe County Department of Public Health (MCDPH) has one representative spot on the CHIW team which also includes members who are community experts from the Finger Lakes Health Systems Agency (FLHSA) and representation from the regional DSRIP initiative, Finger Lakers Performing Provider System (FLPPS). The CHIW is facilitated by the Center for Community Health within UR Medicine and each hospital contributes financially to maintain the leadership, meetings and assessment process. Although the CHIW meetings are not advertised to the public, anyone is welcome to attend. Information discussed at the meeting is shared with hospital leadership and to various community groups for input and comments as team members feel is appropriate. Documented below is the 2016 CHIW Membership List.

Community Health Improvement Workgroup Membership List 2016

Name	Title	Affiliation
Theresa Green, PhD, MBA	Director of Community Health Policy and Education	Center for Community Health, URMC
Shannon Klymochko	Health Project Coordinator – Policy	Center for Community Health, URMC
Kathy Carelock Anne Kern	Manager, Division of Epidemiology Public Health Programs Coordinator	Monroe County Department of Public Health
Lisa Thompson	Director of Public Relations	Highland Hospital
Bridgette Wiefling, MD	Chief Quality and Innovations Officer	Rochester Regional Health
Alida Merrill	Senior Director Quality and Innovations	Rochester Regional Health
Anthony Minervino Jim Sutton, PA-C	Medical Groups	Unity Rochester General
Kathy Parrinello, RN, PhD	Associate VP and COO	Strong Memorial Hospital
Mardy Sandler	Chief Social Worker	Strong Memorial Hospital
Catie Kunecki	Regional Planner	Finger Lakes Health Systems Agency

2016-2018 MC-CHIP Report

1. Community served

Monroe County is located in western New York, centered on the City of Rochester, with 19 suburban and rural towns. The population estimate for Monroe County in 2015 is 749,600 persons, which represents a 0.7% increase from the 2010 Census figure of 744,344. The estimate for the City of Rochester is 209,802 in 2015, down 0.3% since 2010. The average household size in Monroe County is 2.41. According to the 2015 population estimates, the population aged 5 or younger is 5.6% and those age 65 and over makes up 15.9%.

Fifteen percent or 112,479 of Monroe County residents are African-American; of those, 73% reside within the City of Rochester. Of the County's 59,989 Latino citizens, 60% reside in the City of Rochester. The Latino community, mostly of Puerto Rican descent, is the fastest growing segment of the Rochester population.

For the period 2010-2014, it was estimated that 15.4% of people living in Monroe County were living below the poverty level. Rochester is considered the 5th poorest city in the United States among the top 75 metropolitan areas. More than 50% of children in Rochester live in poverty, the highest for any comparably sized city in the US. [1]

A low graduation rate in the City of Rochester is a major socioeconomic issue for the community. Fifty-one percent of the students who entered 9th grade in 2010 in the Rochester City School District graduated four years later. The high school graduation rate county-wide in 2014 was 82%. (Source: NYS Education Department latest data as of June 2016)

One distinct characteristic of Monroe County is the size of the deaf population; an estimated 10,000-15,000 primary American Sign Language (ASL) users. The deaf population is heterogeneous and complex, differentiated along lines of educational background, ASL fluency, age of onset of deafness, as well as race and ethnicity. Racial and ethnic disparities within this group, while likely, have not been well-documented.

Monroe County has a plethora of existing facilities and resources within the community. Specifically, Monroe County enjoys productive collaboration among its hospital systems including University of Rochester Medicine's Strong Memorial Hospital and Highland Hospital, and Rochester Regional Health's Rochester General and Unity Hospital. In addition to the health systems, there is the robust Monroe County Department of Public Health, the regional planning agency, Finger Lakes Health Systems Agency, and many relevant community initiatives. Further details regarding the Rochester community, including descriptions of the hospitals and community based organizations and initiatives, can be found in the complete Community Health Needs Assessment.

[1] Analysis of American Community Survey Data for 2010-2014, ACT Rochester downloaded May 3, 2016 http://www.actrochester.org/sites/default/files/Rochester%27s%20Poverty%20Rate%20Rises%20According%20to%20New%20Census_December%202015.pdf

2. Summary of data reviewed

The Monroe County Community Health Needs Assessment (CHNA) began with a review of the 2013 Monroe County CHNA and the state-required annual Progress Reports for the 2016-2018 MC-CHIP. The CHIW has been meeting monthly during the previous implementation phase, and began reviewing data starting in December 2015. The primary consistent source of data used to prioritize the health needs of our community was the New York State Prevention Agenda, especially the county level dashboards. Several other sources of data were used to assess our community and are given as references in the end notes to this document. Key sources, among others, include:

- Mortality and natality data: New York State birth and death files
- Mortality data from the Office of the Medical Examiner, Monroe County
- Statewide Planning and Research Cooperative Systems (SPARCS) files
- Monroe County Youth Risk Behavior Survey (YRBS)
- Local Monroe County Blood Pressure Registry data of patients diagnosed with hypertension and some identity protected electronic medical record information
- County Health Rankings and Roadmaps. A national tool showing county health outcomes of behavior, clinical care, environment, and socioeconomics. http://www.countyhealthrankings.org/
- NYS Prevention Agenda Dashboard 2013-2018. Information for Monroe County can be found here: https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26
- ACT Rochester is a site critical for data related to the social determinants of health. Data on Monroe County social determinants of health can be found here: http://www.actrochester.org/
- Monroe County Adult Health Survey. This phone survey is very similar to the Behavior Risk Factor Survey administered nationally through the Centers for Disease Control and Prevention (CDC). The Adult Health Survey was first administered in 1997 and was repeated again in 2000, 2006, and most recently in the spring and summer of 2012. In the 2012 survey, 1800 responses were collected. Oversampling was completed in zip codes with high proportions of African American and Latino residents in order to achieve sufficient numbers of responses from these groups.

3. Identification of priority areas

Monroe County has decided to address the following priority areas in this current Plan:

2016-2018 Priority Areas
Monroe County Community Health Improvement Plan (MC-CHIP)

Prevent Chronic Disease	Promote Healthy Women, Infant and Children	Promote Mental Health and Prevent Substance Abuse
Tobacco Use Heart Health	Unplanned Pregnancy Improved Well Child Visits	Opioid Misuse Prevention

The Community Health Improvement Workgroup extensively reviewed and explored data from the sources described above. As discussed, The Prevention Agenda Dashboard for Monroe County was reviewed. We identified Monroe County indicators that were worse than the NYS average and/or they did not meet the Prevention Agenda targets and these served as our primary starting point for identifying priority areas. New data sources were also reviewed including accidental deaths related to heroin/fentanyl, and Adverse Childhood Experiences from the 2014-2015 Monroe County Youth Risk Behavior Survey. Finally, additional time went into examining existing health disparities and finding ways to address them in the 2016-2018 MC-CHIP. The summary list of the top 12 focus areas can be found below. For further description please read the complete CHNA report.

Monroe County Prevention Agenda Measures

12 Focus areas in which indicators are worse than NYS, not at the Target and/or there are large disparities

A detailed list of the data sources used to create this list can be found at the end of the document

1. Reduce obesity in children and adults

- 25% of adults and 15% of children are in the obese weight category
- 50% of newborn infants are exclusively breastfed
- 23% of adults report food insecurity
- These rates are similar to NYS, but there are significant disparities:
    - Adult obesity - about 1.5 times higher Blacks & Latinos compared to whites
    - Child obesity – about 1.5 times higher city compared to suburbs, Blacks & Latinos compared to Whites
    - Breastfeeding – about 2 times lower Blacks & Latinos compared to Whites and Medicaid enrollees compared to those not on Medicaid.
    - Food insecurity – more than 2 times higher Blacks compared to whites

2. **Reduce illness, disability and death related to tobacco use and secondhand smoke exposure**

- 15% of adults smoke
- 11% of pregnant women smoked during pregnancy
- These rates are similar to NYS, but there are significant disparities:
    - Adult smoking –
        - 1.6 times higher Blacks compared to Whites
        - 1.8 times higher low income compared to the total population
        - More than 2 times higher among those who report poor mental health, compared to the total population
    - Smoking during pregnancy
        - 5 times higher Medicaid enrollees, compared to those not on Medicaid
        - 2.3 times higher city compared to suburbs
        - 1.4 times higher Blacks compared to Whites

3. Increase screening for colorectal cancer

- 69% of adults age 50-75 received recommended colorectal cancer screening, which is similar to the rate in NYS.
- Only 43% of Medicaid enrollees however have received the recommended colorectal cancer screening.

4. Promote evidence-based chronic disease care

- The rate of hospitalizations due to short term complications from diabetes is (8/10,000) which is higher than the rate in NYS (6/10,000) and there are significant disparities:
    - 4.3 times higher Blacks compared to Whites
    - 2.2 times higher Latinos compared to Whites

- 70% of those with high blood pressure are in control, but there are significant disparities:
    - 1.3 times lower Blacks & Latinos compared to Whites
    - 1.2 times lower among those who live in low income zip codes compared to those in high income zip codes

5. Reduce violence by supporting violence prevention programs

- The rates of assault related hospitalizations (4.1/100,000) is the same as NYS, however there are significant disparities:
    - 10.4 times higher African Americans compared to Whites
    - 3.4 times higher Latinos compared to Whites
    - 8 times higher low income zip codes compared to rest of the county

6. Increase the % of children who receive comprehensive well child health services in accordance with AAP guidelines

- 71% of children enrolled in Medicaid and child health plus receive the recommended well child visits which is similar to the percentage in NYS (72%)
- 65% of 19-35 month old children are up-to-date on their immunizations, which is slightly higher than the rate in NYS excluding NYC (60%).

7. Reduce premature births

- The premature birth rate (10.5%) is similar to NYS (10.9%), but there are disparities:
    - 1.5 times higher Blacks compared to Whites
    - 1.4 times higher Latinos compared to Whites
    - 1.4 times higher Medicaid enrollees compared to not on Medicaid
- The rate of newborns with a drug related diagnosis (180/10,000) is higher than the rate in NYS (95/10,000)

8. Reduce rates of teen and unplanned pregnancies

- The teen pregnancy rate in Monroe County (17.3/1,000) has declined and is lower than the rate in NYS (19.3) There are still significant disparities:
    - 6 times higher Blacks compared to Whites
    - 5 times higher Latinos compared to Whites
- 32% of births are the result of an unplanned pregnancy, which is higher than the NYS rate (25%) and there are certain populations with high rates:
    - 58% - Blacks
    - 46% -Latinos
    - 53% Medicaid enrollees

9. Decrease sexually transmitted diseases morbidity

- The gonorrhea case rate among females age 15-44 (329/100,00) is 1.7 times higher than the rate in NYS
- The chlamydia case rate among females age 15-44 is (1,932/100,000) is 1.3 times higher than the rate in NYS

10. Prevent, reduce and address adverse childhood experiences (ACES)

- 70% of public high school students and 87% of RCSD students report experiencing one or more adverse childhood experience (trauma)
- 27% of public high school students report feeling sad/hopeless every day for 2+ weeks in past year
- 11% of adults report frequent mental distress

11. Prevent substance abuse (including an emerging issue, heroin deaths)

- 80 residents died from accidental heroin overdose in 2014, a 70% increase since 2013.
- Of public high school students:
    - 22% report using marijuana in the past 30 days
    - 10% report ever using a prescription drug to get high
    - 5% report ever using heroin
    - 15% report binge drinking in the past month
- 19% of adults report binge drinking in the past month

12. Prevent suicides

- The suicide death rate (8.8/100,000) is higher than the rate in NYS (8/100,000)
- 8% of public high school students reporting attempting suicide in the past year and 4% reported an attempt that resulted in an injury that required medical care

Data Sources – 12 Needs of Monroe County

Adult Obesity - Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 - 2014, age adjusted rate. Used crude rates by race. https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n

Childhood Obesity - Monroe County Children's Weight Status, 2012, URMC Department of Pediatrics, funded by the Greater Rochester Health Foundation

Newborn infants exclusively breastfed - Vital Records, NYSDOH, 2013
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=it&ind_id=pa43_0

Food insecurity - Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 - 2014, age adjusted rate. Crude rates by race. **https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n**

Adult smoking - Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 - 2014, age adjusted rate. Crude rates by race, income, poor mental health. https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n

Smoking during pregnancy – Vital Records, 2013 MCDPH

Colorectal cancer screening- Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 -2014, crude rate.

Colorectal cancer screening among Medicaid population - Medicaid Delivery System Reform Incentive Payment (DSRIP) Clinical Metrics, 2013. https://health.data.ny.gov/Health/Medicaid-Delivery-System-Reform-Incentive-Payment-/e2qd-mx59

Rate of hospitalizations for short-term complications of diabetes per 10,000 - Aged 18+ years, 2011-2013 – SPARCS, NYSDOH.
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=/EBI/PHIG/apps/dashboard/pa_dashboard&p=it&ind_id=pa29_0 Data by Race/Latino Origin http://www.health.ny.gov/statistics/community/minority/county/monroe.htm

Control rate among those with High Blood Pressure- FLHSA, June 2015

Assault related hospitalization rates – SPARCS, NYSDOH, 2011-2015.
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

% of children who receive comprehensive well child health services in accordance with AAP guidelines - NYSDOH Office of Quality and Patient Safety, 2013.
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

% of 19-35 month old children up-to-date on their immunizations -Percentage of children with 4:3:1:3:3:1:4 immunization series, NYS Immunization Information System data as of January 2015.
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

Premature birth rate – Vital Records, NYSDOH, 2011-2013
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

Rate of newborns with a drug related diagnosis – SPARCS, NYSDOH, 2011-2013
http://www.health.ny.gov/statistics/chac/hospital/h46.htm

Adolescent pregnancy rate per 1,000 females - Aged 15-17 years –Vital Records, NYSDOH, 2013
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

Percentage of unintended pregnancy among live births- Vital Records, NYSDOH, 2013
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

Gonorrhea case rate per 100,000 women - Aged 15-44 years - NYS STD Surveillance System data, 2013
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

Chlamydia case rate per 100,000 women - Aged 15-44 years - NYS STD Surveillance System data, 2013
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

Public High School Students reporting ACES and Feeling Sad/Hopeless – Youth Risk Behavior Survey, 2014-2015, MCDPH.
http://www2.monroecounty.gov/health-healthdata.php#surveys

Adults Reporting Frequent Mental Distress - Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 -2014, age adjusted rate. https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n

Accidental Heroin Overdoses – Office of the Medical Examiner, Monroe County, NY, 2014

Public High School Students reporting Substance Use and Binge Drinking – Youth Risk Behavior Survey, 2014-2015, MCDPH.
http://www2.monroecounty.gov/health-healthdata.php#surveys

Adults Reporting Binge Drinking - Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 -2014, age adjusted rate. https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n

Age-adjusted suicide death rate per 100,000 – Vital Records, NYSDOH, 2011-2013
https://apps.health.ny.gov/doh2/applinks/ebi/SASStoredProcess/guest?_program=%2FEBI%2FPHIG%2Fapps%2Fdashboard%2Fpa_dashboard&p=ch&cos=26

In order to narrow down the 12 high need focus areas into a manageable and obtainable plan for community health improvement, community input was significantly considered. The CHIW reviewed the results of several community forums and opportunities for input including the forums established for DSRIP in our region as well as reports from the African American Health Coalition and the Latino Health Coalition, the High Blood Pressure Collaborative Focus Groups and the Rochester-Monroe Anti-Poverty Initiative (RMAPI). Discussion of this input is described extensively in the CHNA report. In order to obtain input from health care leaders in our county, the CHIW developed and implemented a survey to inquire about what each hospital and health care organization saw as a priority area.

The survey, which was distributed electronically to hospital leadership, asked several questions based on whether each problem area had the following characteristics:

- IMPORTANCE- how many people are affected, how much disability and illness is caused by this issue, and the long-term impact on health?
- LIKELIHOOD OF IMPACTFUL SUCCESS – Will this result in substantial health improvement in 3-5 years?
- COMMUNITY SUPPORT – how much support is there among community leaders, partner organizations, and residents?
- HOSPITAL SUPPORT – how much support is there among hospital leaders?
- FILL A GAP – will this fill a gap in services/initiatives currently provided in Monroe County?
- LARGE HEALTH DISPARITY – does this initiative address an important disparity?

The results of this survey were then reviewed and compared to the initial community input. Through this process, the workgroup was able to identify the following as the top priority areas for the 2016-2018 Monroe County Community Health Improvement Plan.

4. Implementation Strategy

Several months were spent consulting content experts and discussing among the CHIW members how we can most effectively impact the priority needs identified in the CHNA process.

Please see the grid on the following pages for detailed information regarding each priority area goal, outcome objective(s), intervention(s)/strategies(s)/activities(s), process measure(s), partner role(s).

1. Smoking Cessation

Prevention Agenda Priority Area: Prevent Chronic Disease			
Focus Area #2: Reduce Illness, Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure			
Measure of Success: Reduce the percentage of adults ages18 years and older who currently smoke by 5%, from 15% (eBRFSS, 2013-4) to below 14% among all adults.			
Goals	**Intervention for Action**	**Objective**	**Short term process measures**
Promote tobacco use cessation, especially among low SES populations and those with poor mental health	Promote use of evidence-based tobacco dependence treatments among those who use tobacco	By December 31, 2018, all four hospital-based healthcare systems will enact a tobacco cessation policy that incorporates the "opt-to-quit" program and will implement that policy thereby electronically linking tobacco using patients to the NYS Quit Line. By December 31, 2017 the Rochester Psychiatric Center will enact a tobacco cessation policy that incorporates the "opt-to-quit" program and will implement that policy electronically linking tobacco using patients to the Quit Line.	• # of hospitals adopting robust tobacco policy • # of hospitals electronically linking to NYS Quit Line • # of patients referred to quit line from Monroe Co. • # of patients successfully quitting tobacco after engaged by the QuitLine

Description:
Tobacco addiction is the leading preventable cause of morbidity and mortality in New York State (NYS) and in the United States[1]. The economic costs of tobacco are overwhelming and include both health care costs for smoking-related illnesses and lost productivity. Despite public education and policy to decrease tobacco use, there are still a substantial and troublesome amount of current smokers in Monroe County:

Monroe County Prevention Agenda Measures

- 15% of adults smoke (NYS = 16%, PA Target = 15%)
- These rates are similar to NYS, but there are significant disparities:
    - Adult smoking –
        - 1.6 times higher Blacks compared to Whites (Blacks = 23% compared to Whites = 15%)
        - 1.8 times higher low income compared to the total population (25% among those with income <$25K)
        - More than 2 times higher among those who report poor mental health, compared to the total population (30.7% among those with poor mental health)

(Data on Adult smoking – from the Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 -2014, age adjusted rate. Crude rates by race, income, poor mental health. https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n)

In addition, from the Monroe County Adult Health Survey data (most recent, 2012):

- There are significant disparities in those who smoke. Of those who live in the City of Rochester 25% smoke in comparison to the suburbs where only 13% smoke. In addition, of those who earn <$25,000 per year 23% smoke vs. 14% of those earning more than $25,000
- Of those who smoke daily 49% tried to quit in the past year.

Although preventing people from initiating smoking is the primary goal, getting smokers to quit tobacco is equally important. Much research shows that quit lines are an effective cessation intervention[2] and the reach of quit lines due to access and no/low caller cost means that they can have a huge public health impact. The New York State Smokers' Quitline offers confidential counseling and other cessation-related services to patients who use tobacco products**.** Health care providers can refer their tobacco-using patients to the New York State Smokers' Quitline using several options, the easiest of which is electronically through the EMR. Patients will then receive a follow-up call from a *Quit-Coach* who will provide a stop smoking or stop smokeless-tobacco counseling session to tailor a cessation plan for the patient.

[1] U.S. Department of Health and Human Services. *Reducing the health consequences of smoking: 25 years of progress. A report of the Surgeon General*. US Dept of Health and Human Services, Public Health Service. 1989.

[2] Representative sampling of evidence for quitline effectiveness can be accessed at http://globalqlnetwork.wordpress.com/about-quitlines/the-evidence-base/landmark-research/

Activities and resources the hospitals will contribute:

Strong	Highland	Rochester Psychiatric Center	Rochester Regional Health

- Hospitals will adopt a tobacco cessation policy to include Opt-to-quit
- Hospitals will develop EMR changes to easily refer patients to the NYS Quit Line with electronic transfer of information
- Hospitals will facilitate training to providers about Opt-to-quit and will participate in a quality improvement process of the CHIW to increase number of patients referred to the NYS quit line electronically

Activities and resources the Health Department will contribute:

- Produce tobacco retailer maps (Used by SHAC to educate residents about the impact point-of-sale marketing in their communities.)
- Provide educational sessions related to the NYS smokers quitline to MCDPH program staff and explore how to improve collaboration and increase referrals to the quitline (programs NFP, WIC, healthy neighborhoods, TB, Foster Care)

Activities and resources the Community agencies will contribute:

- The Center for Tobacco Free Finger Lakes will assist with education and training for providers as needed
- The Center for Tobacco Free Finger Lakes will link to resources at the state and will engage health clinics serving patients outside the hospitals (FQHCs for example)
- Roswell Cancer Center will provide technical assistance, expertise about the NYS Quit line, and provide evaluation reports and technical advice to the CHIW leadership for measuring success
- The CHIW leadership will measure success and facilitate an informal quality improvement process whereby data is examined and opportunities for improvement are discussed.
- SHAC – Smoking and Health Action Coalition works to educate the community about the influence of point-of-sale marketing of tobacco products

Prevention Agenda Priority Area: Promote Healthy Women, Infants, and Children

Focus Area #1: Reduce premature birth (through smoking cessation)

Measure of Success: Decrease the percentage of preterm birth especially in Rochester, and especially among Black non-Hispanics, Hispanics, and Medicaid births. Baseline 3 year average 2011-2013:10.5 (Monroe County) and 12.1 (Rochester).

Goals	Intervention for Action	Objective	Short term process measures
Reduce premature birth (through smoking cessation)	Ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who use tobacco. Link tobacco cessation services (Center for Tobacco Free Finger Lakes and NYS Quit Line) to Nurse Family Partnership Program and Baby Love and Centering Pregnancy	By December 31, 2018 decrease the percent of women who smoke during pregnancy from 11% of births (2013 vital statistics) to less than 10% of births, and to especially concentrate on those women who receive Medicaid – Baseline 20% of births were smoking during pregnancy.	• # and % of women for whom tobacco counselling was provided as part of prenatal visit • # of pregnant women referred to quit line • # of pregnant women who decreased tobacco usage during pregnancy

Description:

Monroe County Prevention Agenda Measures

- 11% of pregnant women smoked during pregnancy (2013 Vital Stats)
- These rates are similar to NYS, but there are significant disparities:
  - Smoking during pregnancy
    - 5 times higher Medicaid enrollees (20%), compared to those not on Medicaid
    - 2.3 times higher city compared to suburbs (City = 17%, Suburbs = 8%)
    - 1.4 times higher Blacks compared to Whites (15% for Blacks, 10% for Whites)

(data re: Smoking during pregnancy – taken from Vital Records, 2013 MCDPH

Activities and resources the hospitals will contribute:			
Strong	Highland	Rochester General Hospital	
• The Baby Love Program will work with Center for Tobacco Free Finger Lakes to develop a prescribed strategy for increasing cessation counseling to high-risk pregnant women • Confirm that tobacco cessation is part of Centering Pregnancy curriculum at 7 sites around Monroe County and support this effort as appropriate			
Activities and resources the Health Department will contribute:			
• Nurse Family Partnership will review their smoking cessation counseling process and refer tobacco dependent patients to NYS Quit line and Center for Tobacco Free Finger Lakes as appropriate			
Activities and resources the Community agencies will contribute:			
• The Center for Tobacco Free Finger Lakes will assist with education and training for providers as needed • Info: Healthy Start Case Management screens for tobacco use and provides cessation services referrals • DSRIP supports chronic disease management and prevention as well as the Baby Love and Nurse Family Partnership program.			

2. Heart Health Management and Prevention

Prevention Agenda Priority Area: Prevent Chronic Disease			
Focus Area #3: Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings			
Measure of Success: Increase the percentage of adults ages 18+ years with hypertension who have controlled their blood pressure (according to HEDIS), from 68.9% (local HBP registry Dec 2015) to 71.5% for those in the registry.			
Goals	**Intervention for Action**	**Objective**	**Short term process measures**
Promote evidence-based care to manage chronic diseases	Promote the use of evidence-based interventions to prevent or manage chronic diseases	By December 2018, decrease the disparity among hypertensive residents in the local registry who have their blood pressure in control by increasing the control rate among African Americans (58.8%) and Latinos (61.2%) compared to Whites (75.4%). (Using HEDIS) Increase the control rate for hypertensive patients who also have diabetes	• # of lower performing practices within the registry who serve large portions of AA and Latino populations engaged in interventions. (# patients served ?) • # of community engagement and education activities focused on at-risk populations • HTN control rates by chronic condition • # of participants in Evidence Based Intervention offered by partners
Description: Once people develop a chronic disease, it is important to manage the disease effectively so that it does not progress to a more serious, and more expensive, state. Tertiary prevention is the focus of this priority area. Hypertention is among the many chronic			

diseases prevalent in Monroe County. Several agencies in Monroe County, led by the Rochester Chamber of Commerce and the Finger Lakes Health Systems Agency, have collaborated to address high blood pressure called the Monroe County Blood Pressure Collaborative. Many initiatives are on-going that involve the hospital systems as well as the Monroe County Department of Public Health and community agencies.

High blood pressure affects approximately one in three people in the Rochester area (32% among Monroe County residents) and it is 40% more prevalent among African Americans than among whites. Hypertension can lead to more serious and potentially fatal diseases, such as heart attacks, strokes, kidney disease and other chronic conditions. Prevalence rates in Monroe County are higher among City residents compared to Suburban residents, and among African American residents compared to White residents as shown in the table below.

Blood Pressure and Disparities for Monroe County

Ever Told by a Doctor or Health Professional that they have High Blood Pressure, **Adults Ages 18+, 2012**	City	Suburbs	African American	White
High Blood Pressure	36*	31	43*	31
Source Monroe County Adult Health Survey, 2012				

The Blood Pressure Collaborative collects data on most patients in the region diagnosed with Hypertension. This Blood Pressure Registry enables the planning team to review summary reports twice a year. Although the control rate of HTN increased substantially with our efforts, there has been a plateau of late. Disparity persists however between people of low SES and those of color. From the registry (Dec 2015) 70% of those with high blood pressure are in control, but there are significant disparities:

- 59% of African Americans are in control and 61% of Latinos are in control, compared to 73% of Whites
- 62% of those living in low income zip codes are in control vs. 74% for those living in high income zip codes

<u>Evidence-Based Strategy</u>

Several evidence-based strategies are being implemented through the Blood Pressure Collaborative in Monroe County to keep those with hypertension “in control”. The Goals of the Collaborative

- To improve the number of people in our region who are in control of their blood pressure.
- To do so through community partnerships
- To work with the medical community on transforming care to more proactively identify and effectively treat patients with high blood pressure.

Activities and resources the hospitals will contribute:			
Strong	Highland	Rochester General	Unity

- Hospitals will work with the health department and the community to implement culturally competent health literacy and engagement programs centered around chronic disease prevention and management.
- Hospitals will continue to provide patient information to the registry as requested
- Hospitals will continue to actively participate in the High Blood Pressure Collaborative including sending representation to the meetings
- Hospitals will continue to support the recommendations of the Rochester Chamber of Commerce Health Care Planning Team on issues related to HTN control and will continue to support the recommended funding mechanism as appropriate for each hospital
- Hospitals will continue to support the Heart Advocate Program as fully integrated members in their clinics (formerly the Blood Pressure Advocate Program) as appropriate and as able.
- Hospitals will continue to support and expand where possible the Practice Improvement Consultants program, or similar quality improvement initiatives, especially in practices serving minority populations
- HFM has a 5 month curriculum for residents that has a Practice Improvement (PI) component. The PI portion of this offers teaching in QI and the residents have been doing HTN based projects over the last 3 cycles.
- Hospitals might consider creative evidence-based solutions such as using group visit formats or using medical assistants to engage in panel management for HTN follow up (HFM)
- Hospitals will send representatives to the Diabetes Coalition in Monroe County

Activities and resources the Health Department will contribute:

- Continue to co-chair the Diabetes Coalition
- Assist the hospitals and community in developing culturally competent health literacy and engagement materials and programming centered around chronic disease prevention and management and ensure alignment with DSRIP activities
- Ensure that health care providers and care managers are aware of and know how to refer to community based programs to prevent and manage chronic disease.
- Health department will continue to provide data when needed as appropriate around community based heart health morbidity and mortality.

Activities and resources the Community agencies will contribute:

- The Blood Pressure Collaborative will continue to lead the efforts of coordinating the community efforts towards HTN control in our region
- The Finger Lakes Health Systems Agency will continue to address blood pressure control through community engagement efforts in the churches, barber shops and other community organizations
- The Rochester Chamber of Commerce Health Care Planning Team will continue to support HTN control efforts by overseeing the funding process and allocating resources and support to continue the most effect interventions to increase blood pressure control rates in our region.
- The YMCA offers the Diabetes Prevention Program

Measure of Success: Reduce CHF re-admission rates by four percentage points within Rochester Regional Health.

Goals	Intervention	Objective	Short term process measures
Promote evidence-based care to manage chronic diseases	Promote the use of evidence-based interventions to prevent or manage CHF	Increase the ability of patients with CHF to manage their illness	• Implement evidence based patient education program • Develop home outreach to identify social barriers to disease management • Identify health and medication literacy challenges and implement interventions that enhance medication compliance

Rochester Regional Heath will concentrate efforts on Congestive Heart Failure (CHF) in an effort to reduce CHF re-admission rates by four percentage points. Readmissions for CHF are costly to both patients and the healthcare system. The national average cost of the first admission is $8000.00 and the national average cost of a CHF readmission is $13,000.00. Heart disease is a major cause of CHF and is the #2 cause of death in Monroe County. Helping patients manage their illness and make the necessary lifestyle changes will be critical to improving the outcomes of patients with CHF and reducing total cost of care for our community. RRH will:

- Launch a Steering Team to develop standard educational materials
- Work with Health Homes and Home Care Agencies to provide adequate disease management supports in the home
- Work with CBOs to connect patients to social service needs e.g. housing, transportation

3. Reduce unplanned pregnancy

Prevention Agenda Priority Area: Promote Healthy Women, Infants, and Children			
Focus Area #3: Reproductive, Preconception and Inter-Conception Health			
Measure of Success: Decrease the percent of births that are the result of an unplanned pregnancy from 32% of births in Monroe County (2013 Vital Records)			
Goals	**Intervention for Action**	**Objective**	**Short term process measures**
Reduce rates of teen and unplanned pregnancy	Delivery of evidence based sexual health education Delivery of confidential reproductive health care services for teens in both community and school based clinical settings Integrate preconception and inter-conception care into routine primary care for women of reproductive age including screening and follow-up for risk factors, and contraception	By December 2018, reduce significant barriers to the use of LARC (Long-Acting Reversible Contraception), to decrease the rate of unplanned pregnancy among the Monroe County population By December 2018, increase the number of youth reached with evidence-based sexual health education (baseline measure of current youth being reached is needed)	• % of births due to an unplanned pregnancy in Monroe County • # of identified barriers to LARC insertions • # educational sessions to providers serving women of reproductive age • # of pediatricians committed to following guidelines recommended by CDC and AAP for discussing contraception • # of youth reached by evidence-based programming • # of evidence based programs

Description:
An unintended pregnancy is a pregnancy that is reported to have been either unwanted (that is, the pregnancy occurred when no children, or no more children, were desired) or mistimed (that is, the pregnancy occurred earlier than desired.) Most teen pregnancies are unintended.

Unintended pregnancy is associated with an increased risk of problems for the mother and baby. If a pregnancy is not planned before conception, a woman may not be in optimal health for childbearing. Women who experience an unplanned pregnancy are less likely to get prenatal care than women who plan their pregnancy.[3] The risks of preterm and low birth weight births are significantly higher when there is an unplanned pregnancy.[4] In addition, children born as a result of an unplanned pregnancy are more likely to have physical health problems, behavioral challenges and poorer educational outcomes.[5]

In 2013, 32% of births to Monroe County residents were the result of an unplanned pregnancy, which is higher than the NYS rate (25%). Women enrolled in Medicaid (53%), African American women (58%), Latina women (46%), and women with substance use disorders (60%) are disproportionately affected by unplanned pregnancies in Monroe County. In addition, more than 70% of teen births are a result of an unintended pregnancy. (Source: vital records, MCDPH 2013)

Teen pregnancy and birth rates in Monroe County have significantly declined the past several years. However, rates are 5-6 times higher among Blacks and Latinas compared to Whites. (Source: vital records, MCDPH 2013)

- The teen pregnancy rate in Monroe County (17.3/1,000) has declined and is lower than the rate in NYS (19.3) There are still significant disparities:
  - 6 times higher Blacks (42.4%) compared to Whites (6.7%)
  - 5 times higher Latinos (33.0%) compared to Whites
- 32% of births are the result of an unplanned pregnancy, which is higher than the NYS rate (25%) and there are certain populations with high rates:
  - 58% - Blacks
  - 46% -Latinos
  - 53% Medicaid enrollees

[3] Centers for Disease Control and Prevention. (2006). Recommendations to improve preconception health and health care - United States: a report of the CDC/ ATSDR Preceonception Care Work Group and the Select Panel on Preconception Care. *MMWR;55*(RR-6):1-23.
[4] Kost K, Landry, D.J., and Darroch, J.E. (1998). The effects of pregnancy planning status on birth outcomes and infant care. *Family Planning Perspectives;30* (5):223-230.
[5] Hummer R, Hack, K.A., & Raley, R.K. (2004). Retrospective reports of pregnancy wantedness and child well-being in the United States. *Journal of Family Issues;25*(3):404-428.

Activities and resources the hospitals will contribute:			
Strong	Highland	RRH*	
• The LARC Initiative at URMC will continue working to educate service providers, especially pediatricians, about LARC (GRHF funded) • Hospitals will work to address the Medicaid reimbursement barrier so that LARC devices can be reimbursed when inserted post-partum without decreasing reimbursement for labor and delivery costs. • Hospitals will encourage pediatricians to counsel all patients of childbearing age on contraception according to AAP guidelines and recommendations (with the help of the LARC Initiative) • Hospitals will research the Oregon "One Key Question" initiative (http://www.onekeyquestion.org/) and consider piloting at a clinic. • Explore co-location of family planning services at other service sites including substance use disorder clinics (60% of births to women who used substances during pregnancy were a result of an unintended pregnancy). • Baby Love and Centering Pregnancy will give support to at-risk pregnant women including assistance with strategically planning any future pregnancies			
Activities and resources the Health Department will contribute:			
• Monitor and report on sexual risk behaviors among public high school students through the Monroe County Youth Risk Behavior Survey • Monitor and report on the percent of births that are the result of unplanned pregnancies through vital records data • Assist with identification of barriers to accessing LARC • Nurse Family Partnership Program – ensure clients receive counseling, guidance and support regarding pregnancy planning			
Activities and resources the Community agencies will contribute:			
• Several organizations promote youth development and teen pregnancy prevention efforts in Monroe County. Details about each of these can be found at: https://metrocouncilrochester.org/youth-health-and-youth-development-programs-in-rochester • Family Talk is a proven effective four part parent workshop series that helps parents improve their communication with their children about sexuality and substance abuse. https://metrocouncilrochester.org/family-talk • The Healthy Baby Network is focused on improving health of babies and mothers, especially those of high risk, in Monroe County and Rochester. • "Improving Women's Access to IUD and Implants" conference in Rochester (June 2016) • DSRIP supports the Nurse Family Partnership and the Baby Love program to give support to at-risk pregnant women including assistance with strategically planning any future pregnancies.			

*Rochester Regional Health will be addressing Prevention Agenda Priority Area: Promoting Improved Maternal Child Health Outcomes by addressing Focus Area #2: "Reduction in preterm and low birth weight babies born".

RRH goal is to decrease preterm birth rates. Overall NY state receives a rating of B on the MOD Preterm Report Card, Rochester in particular rates a C rating for preterm birth rate of 9.3-10.3. The average additional cost for each preterm delivery is $37,152 in direct medical care costs. There are significant cost savings for Centering Pregnancy enrolled patients when compared to their peer group who elected to have routine prenatal care due to fewer preterm deliveries. RRH patients participating in initial Centering Pregnancy sites were less likely to have preterm or low birth weight babies.
In 2015, ~ 7.5% of Centering Pregnancy patients in Rochester area programs experienced a preterm delivery as compared to the general population rate of 10.3%.

Goals:	**Intervention for Action**	**Objective**	**Short term process measures**
Reduce preterm birth rate Reduce low birth weight babies (<2,500 g)	Improve prenatal care through Centering Group Prenatal Care RRH will continue to offer Centering Pregnancy prenatal care RRH will use Centering Counts data collection to record outcomes for comparison of data and creation of city-wide report cards RRH will continue to decrease barriers to participation, working to encourage employers to see benefit to their employees participating, seeking funding for drop in center for child care to allow mothers to participate, seeking funding or better utilization of transportation options in urban areas RRH will refer to post natal Community Health Worker programs	By December 31, 2018 reduce percent of preterm deliveries to the 2020 Healthy People recommended goal of 7% for preterm birth and 5% for low birth weight babies born in Monroe County	• Joint reporting of statistics across the county from all sites to give broad picture of the effect this program has on preterm and low birth weight babies • Participate in City Wide annual meeting to review what is happening in all sites and collaborate on reporting of statistics • # of women participating in Centering Pregnancy Prenatal Care

4. Screen children for food insecurity

Prevention Agenda Priority Area: Promote Healthy Women, Infants, and Children			
Focus Area #2: Child Health			
Measure of Success: Decrease the percent of children living in food insecure households from 20.5% (Feeding America, 2014) while also striving to decrease the percent of adults who experienced food insecurity in the past year – worried or stressed about having enough money to buy nutritious meals (EBRFSS2013-4) from 23% in Monroe County.			
Goals	**Intervention for Action**	**Objective**	**Short term process measures**
Increase the percentage of children who receive comprehensive well-child health services in accordance with AAP guidelines AAP recommends screening for food insecurity PEDIATRICS Volume 136, number 5, December 2015	Develop, disseminate, promote and utilize tools for providers to prompt or facilitate well-child visit components, including checklists, registries, data systems and electronic health records	By December 2018, increase the number of children who are receiving food insecurity screenings according to AAP guidelines in Monroe County. (baseline is not measured but estimated to be zero)	• Number of (pediatric) clinics screening for food insecurity • Number of families screened for food insecurity • Number of families screening positive for food insecurity • Number of families engaging resources to address food insecurities
Description: Food insecure households are households in which access to adequate food is limited by a lack of money or other resources."[6] Several health issues have been strongly associated with food insecurity.[7] Lack of access to food in families contributes to depression, anxiety, and toxic stress.[8] Developmental and behavioral problems along with reduced academic achievement have also			

[6] Coleman-Jensen A, Gregory C, Singh A. Household Food Security in the United States in 2013. Publication no. ERR-173. Washington, DC: US Department of Agriculture, Economic Research Service; September 2014

[7] Cook JT, Black M, Chilton M, et al. Are food insecurity's health impacts underestimated in the US population? Marginal food security also predicts adverse health outcomes in young US children and mothers. Adv Nutr. 2013; 4(1):51–61

[8] Rose-Jacobs R, Black MM, Casey PH, et al. Household food insecurity: associations with at-risk infant and toddler development. Pediatrics. 2008;121(1):65–72pmid:18166558

been linked with food insecurity. [9,10] Although not a direct cause of obesity, food insecurity disproportionately affects populations at highest risk of obesity.[11] Children in food insecure households tend to have limited access to high quality foods due to residing in neighborhoods with limited full service grocery stores. Inconsistent availability of food, may also lead to unhealthy eating patterns.

In 2015 the American Academy of Pediatrics (AAP) issued a recommendation during well child visits, pediatricians utilize a 2-question validated tool to screen for food insecurity and refer to community programs. [12]

According to the Feeding America, Map the Meal Gap Project, 20.5% of children in Monroe County live in households experiencing food insecurity.[13] Fifteen percent of Monroe County children are in the obese weight category. The rate is significantly higher within the City of Rochester (22%) compared to the suburbs (12%).[14]

Monroe County Prevention Agenda Measures: **Food Insecurity only***

- 23% of adults report food insecurity
  - Food insecurity – more than 2 times higher Blacks compared to whites

    Data for Food insecurity – from Expanded Behavioral Risk Factor Surveillance Survey (eBRFSS) Health Indicators by County and Region: 2013 -2014, age adjusted rate. Crude rates by race. https://health.data.ny.gov/Health/Expanded-Behavioral-Risk-Factor-Surveillance-Surve/jsy7-eb4n

- 20.5% of children live in food insecure households.

  Data for Food insecurity – http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2014/NY_AllCounties_CDs_CFI_2014.pdf

- 71% of children enrolled in Medicaid and child health plus receive the recommended well child visits which is similar to the percentage in NYS (72%)
- 65% of 19-35 month old children are up-to-date on their immunizations, which is slightly higher than the rate in NYS excluding NYC (60%).
- 70% of public high school students and 87% of RCSD students report experiencing one or more adverse childhood experience (trauma)
- 11% of adults report frequent mental distress

[9] Rose-Jacobs R, Black MM, Casey PH, et al. *Household food insecurity: associations with at-risk infant and toddler development. Pediatrics. 2008;121(1):65–72pmid:18166558*
[10] Jyoti DF, Frongillo EA, Jones SJ. Food insecurity affects school children's academic performance, weight gain, and social skills. J Nutr. 2005;135(12):2831–2839pmid:16317128
[11] Institute of Medicine. *Hunger and Obesity: Understanding a Food Insecurity Paradigm: Workshop Summary. Washington, DC: National Academies Press; 2011*
[12] Policy Statement: Promoting Food Security for All Children COUNCIL ON COMMUNITY PEDIATRICS, COMMITTEE ON NUTRITIONPEDIATRICS Volume 136, number 5, December 2015. www.pediatrics.org/cgi/doi/10.1542/peds.2015-3301
[13] http://www.feedingamerica.org/hunger-in-america/our-research/map-the-meal-gap/2014/NY_AllCounties_CDs_CFI_2014.pdf
[14] Monroe County Children's Weight Status, 2012, URMC Department of Pediatrics, funded by the Greater Rochester Health Foundation

Activities and resources the hospitals will contribute:			
Strong	Highland	RRH*	
• Hospitals will support piloting a 2-question screening for food insecurities, as recommended by the AAP, in at least 3 clinics with at least two clinics serving a pediatric population. • If successful, hospitals will support integrating the 2-question screening tool, and associated evidence based algorithm, into the EMR and linking patients electronically to resources • Hospitals will support the process of quality improvement in identifying best practices and working towards process improvement by sending representation to a subgroup that will work on this initiative and champion the efforts within their health system			
Activities and resources the Health Department will contribute:			
• The Health department will work with the CHIW to help identify and organize helpful resources for those who are food insecure			
Activities and resources community organizations will contribute:			
• Foodlink, the local food hub, provides extensive resources to address food insecurity • Rochester has emergency food, curbside markets, farm stands, kids café, backpack program • Food programs – summer meals, school meals, WIC, SNAP, Nutrition Education and Outreach Program, at Legal Assistance at Western NY to assistance with applying for SNAP • Community gardens, City of Rochester, AARP and Cornell extension can all provide valuable information and linkages to community resources • FLPPS is applying to initiate a project that screens residents for social need and links residents with resources to address social determinants of health. In addition, DSRIP (FLPPS) promotes the use of the PAM screening tool to activate patients in their care. • HealthiKids is a community coalition that supports an agenda that calls for better school food, safer play areas, food standards at childcare centers, at least 60 minutes of in-school physical activity, and policies that support breastfeeding. HealthiKids supports summer lunch for kids in Rochester			

*RRH will support this initiative in Monroe and will consider piloting if a clinic is particularly interested in participating.

5. Opioid overdose prevention

Prevention Agenda Priority Area: Promote Mental Health and Prevent Substance Abuse			
Focus Area #2: Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders			
Measure of Success: Reduce the number of ED visits due to adverse effects of heroin and prescription drug abuse, including overdose, medical complications and relief from addiction. (Cited in OMH RFA)			
Goals	**Intervention for Action**	**Objective**	**Short term process measures**
Prevent underage drinking, non-medical use of prescription pain relievers by youth, and excessive alcohol consumption by adults Focus only on non-medical use of prescription pain relievers and heroin	Interventions will be overseen and suggested by the newly formed Opioid Prevention Task Force. We support the public health model for the prevention of drug overdose Model components include: 1. Coalition building 2. Prescriber education 3. Supply reduction 4. Pain patient services/drug safety 5. drug treatment 6. harm reduction (naloxone) 7. community based prevention education 8. evaluation	By December 2018, decrease the number of deaths due to opioid overdose from 69 in 2015 (Medical Examiners report of 2015).	• # providers participating in opioid prescribing training • # participating in naloxone training • # of public awareness events to change attitudes, beliefs and norms towards prescription opiates • # of coalition members represented on Opioid Prevention TF (OPTF) • # deaths due to opioid overdose • # of ED admissions due to misuse of opioid • # of services for outpatient crisis intervention
Description: Substance abuse disorders have a substantial impact not only individuals affected by the disorder, but their families and the community as a whole. The problem of substance abuse contributes to social, physical, mental and public health problems including crime, homicides,			

domestic violence, child abuse, suicides, motor vehicle crashes, sexually transmitted diseases, HIV/AIDS, Hepatitis C, and teen pregnancy.[15]

Deaths due to substance abuse are increasing dramatically across the country. According to the CDC, more people died from drug overdoses in 2014 than in any year on record. The majority of these deaths (more than six out of ten) involve an opioid (prescription opioid, fentanyl or heroin). The rate of overdose deaths involving opioids (including prescription opioid pain relievers and heroin) has nearly quadrupled since 1999. Seventy-eight Americans die every day from an opioid overdose.[16]
Locally there has been a significant increase in deaths related to heroin and non-pharmaceutical fentanyl as shown in the table below.

	2011-2013	2014	2015*
Number of Deaths related to the use of heroin and/or non-pharmaceutical fentanyl- that occurred in Monroe County	78	81	69

Source: Monroe County Office of the Medical Examiner (2/22/2016) *provisional

The impact of addiction is seen across the health system in Monroe County. The number of emergency department (ED) visits with a primary diagnosis of any substance abuse increased from 4,516 in 2010 to 5,775 in 2014. ED visits due to heroin overdoses increased from 20 in 2010 to 213 in 2014, while hospitalizations increased from 12 in 2010 to 88 in 2014. (Source: SPARCS, FLHSA).

Drug use during pregnancy appears to be increasing. In 2013, there were 698 births to Monroe County women that had documentation in the birth record of illegal drug use during pregnancy. The percentage of births with drug use during pregnancy nearly doubled between from 4.7% of all births 2005 to 8.4% in 2013. (Source: Vital Records, MCDPH) In addition, the newborn drug-related diagnosis rate per 10,000 newborn discharges more than tripled between 2005 and 2013, from 58.5/10,000 to 215/10,000. In 2013 there were 177 newborn discharges with this diagnosis. (Source: SPARCS, NYSDOH)

[15]US Department of Health and Human Services (HHS), Office of Disease Prevention and Health Promotion. Healthy People 2010 midcourse review: Focus area 26, substance abuse [Internet]. Washington: HHS; 2006 [cited 2010 April 12]. https://www.healthypeople.gov/2020/topics-objectives/topic/substance-abuse#one
[16] Centers for Disease Control and Prevention. Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014. MMWR 2015; 64;1-5. http://www.cdc.gov/drugoverdose/epidemic/index.html

Activities and resources the hospitals will contribute:			
Strong	Highland	Rochester General	Unity
• Hospitals will actively engage in the Opioid Prevention Task Force including having representation at the meetings • Hospitals will discuss the most effective use of Naloxone in the practice setting • Hospitals will support the use of alternatives to opioid pain management when appropriate • Hospitals will discuss sharing de-identified information about ED visits due to misuse of opioids • Hospitals will increase the number of services for outpatient crisis intervention (RRH) • Hospitals (Highland) has started a Controlled Substance Safety Committee that is made up of practice leadership and residents. This committee has the following aims: o To provide guidance and recommendations for safe prescribing of controlled substances to patients using current evidence based treatment practices. To also promote adherence and education to patients and staff in regards to safe controlled substance prescribing using HFMs controlled substance agreement and practice policy.			
Activities and resources the Health Department will contribute:			
• Actively engage in the Monroe County Opioid Task Force • Annually share compiled data of the results of the Medical Examiner Report related to opioid deaths with the Monroe County Opioid Task Force • Monitor prescription drug use and heroin use among public high school students through the Youth Risk Behavior Survey			
Activities and resources the Community agencies will contribute:			
• DSRIP project Project 4.a.iii: Strengthen Mental Health and Substance Abuse Infrastructure Across System – a deliverable is to define/disseminate best practice interventions in pain and anxiety management, including local resources for alternatives to medication-based treatment • The Monroe County Opioid Prevention Task Force- led by the National Council on Alcoholism and Drug Dependence – Rochester Area (NCADD-RA), DePaul with representation from MCMS, law enforcement, DA, Family Recovery Network, MC OMH, MC Public Safely/Emergency Medical Services and health systems (The task force will identify barriers to reducing ED visits and deaths due to the adverse effects of opiates/heroin and prioritize potential community interventions). • The National Council on Alcoholism and Drug Dependence – Rochester Area (NCADD-RA), DePaul provides Community education of prescription drug misuse and heroin use • Trillium health and others are developing and promoting Naloxone training program • Family Recovery Network has family education programs • Monroe County Medical Society Quality Collaborative – working to update their Community Principles for Pain Management (including guidelines related to opioids). Once finalized it will be distributed to providers. Go to http://www.mcms.org/community-principles to see current Principles.			

Quarterly Timeline and Performance Measures

Focus # 1
Prevent Chronic Disease: Smoking Cessation
Reduce Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure

Objective 1.1: By December 2018, all four hospital-based healthcare systems will enact a tobacco cessation policy that incorporates the "opt-to-quit" program and will implement that policy thereby electronically linking tobacco using patients to the NYS Quitline.

Objective 1.2: By December 2018, the Rochester Psychiatric Center (RPC) will enact a tobacco cessation policy that incorporates the "opt-to-quit" program and will implement that policy electronically linking tobacco using patients to the quit line.

Activities	**Q3 '16**	**Q4 '16**	**Q1 '17**	**Q2 '17**	**Q3 '17**	**Q4 '17**	**Q1 '18**	**Q2 '18**	**Q3 '18**	**Q4 '18**
Ensure that all 4 hospitals, RPC and FQHC's have a passed policy that supports Opt-to-Quit™		X								
Develop a Steering Committee for the initiative		X								
Steering Committee to develop a specific action plan		X	X							
Conclude the development of the final EMR changes		X	X							
Implement EMR changes at each hospital			X	X						
Hospitals facilitate training to providers about Opt-to-Quit ™(to increase referrals)			X	X	X	X	X	X	X	X
Evaluate the effectiveness of the Opt-to-Quit program at RPC and report results to the CHIW	X	X	X	X	X	X	X	X	X	X

Additional action items specifically related to Objective 1.2 (implementing Opt-to-Quit™) at RPC):

Activities	**Q3 '16**	**Q4 '16**	**Q1 '17**	**Q2 '17**	**Q3 '17**	**Q4 '17**	**Q1 '18**	**Q2 '18**	**Q3 '18**	**Q4 '18**
Identify champion to help with the implementation of Opt-to-Quit™ at RPC	X									
Obtain baseline measurement for the number of referrals RPC makes to the NYS Quitline™		X								

Objective 1.3: By December 2018, decrease the percent of women who smoke during pregnancy from 11% of births (2013 vital statistics) to less than 10% of births, and to especially concentrate on those women who receive Medicaid – baseline 20% of births were smoking during pregnancy

Activities	**Q3 '16**	**Q4 '16**	**Q1 '17**	**Q2 '17**	**Q3 '17**	**Q4 '17**	**Q1 '18**	**Q2 '18**	**Q3 '18**	**Q4 '18**
Identify champions from NFP, Baby Love and Centering Pregnancy	X									
Coordinate a meeting(s) where all champions meet with Center for Tobacco Free Finger Lakes (CFTFFL) to discuss existing program policies and procedures surrounding the smoking cessation counseling of pregnant women	X	X	X							
Create an action plan to improve smoking cessation counseling for pregnant women		X	X							
Implement changes to smoking cessation services for pregnant women at each organization			X							
Evaluate short term process measures identified in CHIS			X	X	X	X	X	X	X	X

Focus # 2

Prevent Chronic Disease: Heart Health Management and Prevention

Increase Access to Quality Chronic Disease Prevention and Management in Clinical and Community Settings

Objective 2.1: By December 2018, decrease the disparity among hypertensive residents in the local registry who have their blood pressure in control by increasing the control rate among Monroe County African Americans [58.8% and Latinos (61.5%) compared to Whites (75.4%)]

Objective 2.2: Increase the control rate for hypertensive patients who also have diabetes

Activities	**Q3 '16**	**Q4 '16**	**Q1 '17**	**Q2 '17**	**Q3 '17**	**Q4 '17**	**Q1 '18**	**Q2 '18**	**Q3 '18**	**Q4 '18**
The Community Health Improvement Workgroup (CHIW) will continue to maintain the responsibilities they have in the years past related to High Blood Pressure (ex: contribute to the registry, participate in High Blood Pressure Collaborative (HBPC), support the Greater Rochester Chamber of Commerce (GRCC) recommendations, and support the Heart Advocate Program (HAP).	X	X	X	X	X	X	X	X	X	X
MCDPH to continue to co-chair the coalition with the American Diabetes Association.	X	X	X	X	X	X	X	X	X	X
Hospitals to identify a representative to attend the Diabetes Coalition of Monroe Meeting		X	X	X	X	X	X	X	X	X
Create Steering Committee for Health Literacy and Cultural Competency		X	X							
Steering Committee to research culturally relevant programs that support health literacy			X	X	X					
Develop a way to implement culturally relevant programs that support health literacy						X	X			
Implement culturally relevant programs that support health literacy							X	X	X	X
Evaluate the success of all ongoing and new initiatives	X	X	X	X	X	X	X	X	X	X

Please Note - Objective 2.3 (Increase the ability of patients with CHF to manage their illness) applies to RRHS only. Rochester Regional has developed their own timeline for this initiative.

Focus # 3

Promote Healthy Women, Infants and Children: Reduce Unplanned Pregnancy

Reproductive, Preconception and Inter-Conception Health

Objective 3.1: By December 2018, reduce significant barriers to the use of LARC (Long-Acting Reversible Contraception), particularly among at-risk women of reproductive age.

Objective 3.2: By December 2018, increase the number of youth reached with evidence-based sexual health education (baseline measure of current youth being reached is needed)

Activities	**Q3 '16**	**Q4 '16**	**Q1 '17**	**Q2 '17**	**Q3 '17**	**Q4 '17**	**Q1 '18**	**Q2 '18**	**Q3 '18**	**Q4 '18**
Continuation of GRHF funded LARC activities (Grant ending 4/30/17)	X	X	X	X						
Develop plan to encourage pediatricians to support LARC initiative		X	X							
Implement plan to encourage pediatricians to support LARC initiative			X	X						
Obtain baseline measurement of the current number of youth who receive evidence-based sexual health education	X	X								
Develop plan to increase the number of youth receiving evidence-based sexual health education		X	X							
Implement a plan to increase the number of youth receiving evidence-based sexual health education			X	X	X	X	X	X	X	X
Review "One Key Question" initiative at CHIW meeting and decide if it would make a good pilot program…implement accordingly.					X	X				
Evaluate and discuss the progress made at each CHIW meeting	X	X	X	X	X	X	X	X	X	X

Please Note - Objective 3.2 (Improve prenatal care through Centering Group Prenatal Care to reduce the preterm birth rate) applies to RRHS only. Rochester Regional has developed their own timeline for this initiative

Focus # 4

Promote Healthy Women, Infants and Children: Screen for Food Insecurity

Child Health

Objective 4.1: Decrease the percent of children living in food insecure households from 20.5% (Feeding America, 2014) while also striving to decrease the percent of adults who experienced food insecurity in the past year – worried or stressed about having enough money to buy nutritious meals (EBRFSS2013-4) from 23% in Monroe County.

Activities	**Q3 '16**	**Q4 '16**	**Q1 '17**	**Q2 '17**	**Q3 '17**	**Q4 '17**	**Q1 '18**	**Q2 '18**	**Q3 '18**	**Q4 '18**
Identify a champion from each organization to spearhead project	X	X								
Identify clinics able and willing to participate (3 clinics/hospital with a minimum of 2 pediatric clinics/hospital)	X	X								
Create a resource guide to help link those identified as food insecure to resources within Monroe County			X	X						
Organize a team of IT professionals who can help facilitate the necessary EMR changes		X	X							
Have IT department develop the screening form according to the AAP guidelines			X	X						
Implement the EMR change and provide resource guide to patients identified as food insecure.					X	X				
Evaluate the effectiveness of the EMR changes							X	X	X	X
If pilots are successful – the CHIW will being looking at implementing system wide changes at each hospital							X	X	X	X

Focus # 5

Promote Mental Health and Prevent Substance Abuse: Opioid Misuse Prevention

Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders

Objective 5.1: By December 2018, decrease the number of deaths due to opioid overdose from 69 in 2015 (Medical Examiners report of 2015).

Activities	**Q3 '16**	**Q4 '16**	**Q1 '17**	**Q2 '17**	**Q3 '17**	**Q4 '17**	**Q1 '18**	**Q2 '18**	**Q3 '18**	**Q4 '18**
Identify a champion to participate in all Opioid Prevention Task Force meetings	X									
Invite DSRIP 4.a.iii manager to join CHIW	X									
Coordinate meeting(s) for champions to discuss and identify the most effective ways to use Naloxone		X	X	X						
Continue to monitor prescription drug use and heroin use among Monroe County Residents	X	X	X	X	X	X	X	X	X	X
Discuss de-identifying information about ED visits as a mean to monitor prescription drug use and heroin use among Monroe County Residents (noted above)					X	X				
Evaluate the success of interventions using the short term process measures noted in our plan	X	X	X	X	X	X	X	X	X	X

Please Note: Highland and RRHS both have additional action items related to this objective.

- Highland: will continue to meet with their Controlled Substance Safety Committee to discuss the guidelines and recommendations for prescribing controlled substances
- RRHS: Increase the number of services for outpatient crisis intervention

Role and Contributions of Each Hospital and the Local Health Department

Strong Memorial Hospital (URM)

Prevent Chronic Disease: Smoking Cessation (UR - Strong)

Reduce Illness Disability and Death Related to Tobacco and Secondhand Smoke Exposure
• Hospital will adopt a tobacco cessation policy to include Opt-to-Quit™ • Hospital will develop EMR changes to easily refer patients to the NYS Quitline with electronic transfer of information • Hospital will facilitate training to providers about Opt-to-Quit™ and will participate in a quality improvement process of the CHIW to increase number of patients referred to the NYS quit line electronically
Reduce premature birth (through smoking cessation)
• Center for Tobacco Free Finger Lakes will continue to provide cessation material and training • The Baby Love Program will work with Center for Tobacco Free Finger Lakes to develop a prescribed strategy for increasing cessation counseling to high-risk pregnant women • Hospitals will confirm that tobacco cessation is part of Centering Pregnancy curriculum and support this effort as appropriate

Heart Health Management and Prevention (UR - Strong)

Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
• Hospital will work with the health department and the community to implement culturally competent health literacy and engagement programs centered around chronic disease prevention and management • Hospital will continue to provide patient information to the High Blood Pressure registry as requested through the High Blood Pressure Collaborative (HBPC) • Hospital will continue to actively participate in the High Blood Pressure Collaborative including sending representation to the meetings • Hospital will continue to support the recommendations of the Rochester Chamber of Commerce Health Care Planning Team on issues related to HTN control and will continue to support the recommended funding mechanism as appropriate for each hospital • Strong will continue to support and manage the Heart Advocacy Program (HAP, formerly the BPAP program) while funding and support is available. • Hospital will continue to support the Heart Advocates through the HAP as fully integrated members in their clinics as appropriate and able • Hospital will continue to support and expand where possible a quality improvement initiative to address HTN control, including the Practice Improvement Consultants program, especially in practices serving minority populations • Hospital will send representatives to the Diabetes Coalition in Monroe County in order to address the co-morbidity of HTN and Diabetes.

Reduce Unplanned Pregnancy (UR - Strong)

Reproductive, Preconception and Inter-Conception Health
Activities and resources the hospital will contribute: • The LARC Initiative at URMC will continue working to educate service providers, especially pediatricians, about LARC (GRHF funded)

- Hospitals will work to address the Medicaid reimbursement barrier so that LARC devices can be reimbursed when inserted post-partum without decreasing reimbursement for labor and delivery costs.
- Hospital will encourage pediatricians to counsel all patients of childbearing age on contraception according to AAP guidelines and recommendations (with the help of the LARC initiative)
- Hospital representatives to CHIW will research the Oregon "One Key Question" initiative (http://www.onekeyquestion.org/) and consider piloting at a clinic.
- Explore co-location of family planning services at other service sites including substance use disorder clinics (60% of births to women who used substances during pregnancy were at a result of an unintended pregnancy).
- Baby Love and Centering Pregnancy will give support to at-risk pregnant women including assistance with strategically planning any future pregnancies

Screen children for food insecurity (UR - Strong)

Child Health
Activities and resources the hospital will contribute: • Hospital will support piloting a 2-question screening for food insecurities, as recommended by the AAP, in at least 3 clinics (total in Monroe County from all hospitals) with at least two clinics serving a pediatric population • If successful, hospital will support integrating the 2-question screening tool, and associated evidence based algorithm, into the EMR and linking patients electronically to resources • Hospital will support the process of quality improvement in identifying best practices and working towards process improvement by sending representation to a subgroup that will work on this initiative and champion the efforts within their health system

Opioid overdose prevention (UR - Strong)

Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
Activities and resources the hospital will contribute: • Hospital will actively engage in the Opioid Prevention Task Force including having representation at the meetings • Hospital representatives will discuss he most effective use of Naloxone in the practice setting • Hospital will support the use of alternatives to opioid pain management when appropriate • Hospital will discuss sharing de-identified information about ED visits due to misuse of opioids

Highland Hospital (URMC)

Prevent Chronic Disease: Smoking Cessation (UR - Highland)

Reduce Illness Disability and Death Related to Tobacco and Secondhand Smoke Exposure
• Hospital will adopt a tobacco cessation policy to include Opt-to-Quit™ • Hospital will develop EMR changes (in conjunction with EMR changes at Strong) to easily refer patients to the NYS Quitline with electronic transfer of information • Hospital will facilitate training to providers about Opt-to-Quit™ and will participate in a quality improvement process of the CHIW to increase number of patients referred to the NYS quit line electronically
Reduce premature birth (through smoking cessation)
• Hospitals will support the Nurse Family Partnership, Baby Love, and Centering Pregnancy Programs in their efforts to work with Center for Tobacco Free Finger Lakes to develop a prescribed strategy for increasing cessation counseling to high-risk pregnant women • Hospitals will confirm that tobacco cessation is part of Centering Pregnancy curriculum and support this effort as appropriate

Heart Health Management and Prevention (UR - Highland)

Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
• Hospital will work with the health department and the community to implement culturally competent health literacy and engagement programs centered around chronic disease prevention and management • Hospital will continue to provide patient information to the High Blood Pressure registry as requested through the High Blood Pressure Collaborative (HBPC) • Hospital will continue to actively participate in the High Blood Pressure Collaborative including sending representation to the meetings • Hospital will continue to support the recommendations of the Rochester Chamber of Commerce Health Care Planning Team on issues related to HTN control and will continue to support the recommended funding mechanism as appropriate for each hospital • Hospital will continue to support the Heart Advocates through the HAP as fully integrated members in their clinics as appropriate and able • Hospital will continue to support and expand where possible a quality improvement initiative to address HTN control, including the Practice Improvement Consultants program, especially in practices serving minority populations • Hospital will send representatives to the Diabetes Coalition in Monroe County in order to address the co-morbidity of HTN and Diabetes. • Highland Family Medicine has a 5 month curriculum for residents that has a Practice Improvement (PI) component. The PI portion of this offers teaching in QI and the residents have been doing HTN based projects over the last 3 cycles. • Highland Family Medicine might consider creative evidence-based solutions such as using group visit formats or using medical assistants to engage in panel management for HTN follow up

Reduce Unplanned Pregnancy (UR - Highland)

Reproductive, Preconception and Inter-Conception Health
Activities and resources the hospital will contribute: • Hospitals will work to address the Medicaid reimbursement barrier so that LARC devices can be

reimbursed when inserted post-partum without decreasing reimbursement for labor and delivery costs.
- Hospital will encourage pediatricians to counsel all patients of childbearing age on contraception according to AAP guidelines and recommendations (with the help of the LARC initiative)
- Hospital representatives to CHIW will research the Oregon "One Key Question" initiative (http://www.onekeyquestion.org/) and consider piloting at a clinic.
- Explore co-location of family planning services at other service sites including substance use disorder clinics (60% of births to women who used substances during pregnancy were at a result of an unintended pregnancy).
- Hospitals will support the Nurse Family Partnership, Baby Love, and Centering Pregnancy Programs in their efforts to give support to at-risk pregnant women including assistance with strategically planning any future pregnancies

Screen children for food insecurity (UR – Highland)

Child Health
Activities and resources the hospital will contribute: • Hospital will support piloting a 2-question screening for food insecurities, as recommended by the AAP, in at least 3 clinics (total in Monroe County from all hospitals) with at least two clinics serving a pediatric population • If successful, hospital will support integrating the 2-question screening tool, and associated evidence based algorithm, into the EMR and linking patients electronically to resources • Hospital will support the process of quality improvement in identifying best practices and working towards process improvement by sending representation to a subgroup that will work on this initiative and champion the efforts within their health system

Opioid overdose prevention (UR - Highland)

Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
Activities and resources the hospital will contribute: • Hospital will actively engage in the Opioid Prevention Task Force including having representation at the meetings • Hospital representatives will discuss he most effective use of Naloxone in the practice setting • Hospital will support the use of alternatives to opioid pain management when appropriate • Hospital will discuss sharing de-identified information about ED visits due to misuse of opioids

Rochester General Hospital (RRH)

Prevent Chronic Disease: Smoking Cessation (RRH - RGH)

Reduce Illness Disability and Death Related to Tobacco and Secondhand Smoke Exposure
• Hospital will adopt a tobacco cessation policy to include Opt-to-Quit™ • Hospital will develop EMR changes to easily refer patients to the NYS Quitline with electronic transfer of information • Hospital will facilitate training to providers about Opt-to-Quit™ and will participate in a quality improvement process of the CHIW to increase number of patients referred to the NYS quit line electronically
Reduce premature birth (through smoking cessation)
• Hospitals will support the Nurse Family Partnership, Baby Love, and Centering Pregnancy Programs in their efforts to work with Center for Tobacco Free Finger Lakes to develop a prescribed strategy for increasing cessation counseling to high-risk pregnant women • Hospitals will confirm that tobacco cessation is part of Centering Pregnancy curriculum and support this effort as appropriate

Heart Health Management and Prevention (RRH - RGH)

Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
• Hospital will work with the health department and the community to implement culturally competent health literacy and engagement programs centered around chronic disease prevention and management • Hospital will continue to provide patient information to the High Blood Pressure registry as requested through the High Blood Pressure Collaborative (HBPC) • Hospital will continue to actively participate in the High Blood Pressure Collaborative including sending representation to the meetings • Hospital will continue to support the recommendations of the Rochester Chamber of Commerce Health Care Planning Team on issues related to HTN control and will continue to support the recommended funding mechanism as appropriate for each hospital • Hospital will continue to support the Heart Advocates through the HAP as fully integrated members in their clinics as appropriate and able • Hospital will continue to support and expand where possible a quality improvement initiative to address HTN control, including the Practice Improvement Consultants program, especially in practices serving minority populations • Hospital will send representatives to the Diabetes Coalition in Monroe County in order to address the co-morbidity of HTN and Diabetes.
Reduce Congestive Heart Failure (CHF) re-admission rates by 4 percentage points within Rochester Regional Health
• RRH will launch a Steering Team to develop standard educational materials • RRH will work with Health Homes and Home Care Agencies to provide adequate disease management supports in the home • RRH will work with CBOs to connect patients to social service needs e.g. housing, transportation

Reduce Unplanned Pregnancy – RRH will not actively participate, but will instead concentrate on reducing preterm and low birth weight babies (RRH - RGH)

Reproductive, Preconception and Inter-Conception Health
RRH will • Improve prenatal care through Centering Group Prenatal Care • Continue to offer Centering Pregnancy prenatal Care • Use Centering Counts data collection to record outcomes for comparison of data and creation of city-wide report cards • Continue to decrease barriers to participation working to encourage employers to see benefits to their employees participating, seeking funding for drop in center for child care to allow mothers to participate, seeking funding for better utilization of transportation options in urban areas • Refer to post-natal Community Health Worker programs

Screen children for food insecurity (RRH - RGH)

Child Health
Activities and resources the hospital will contribute: • RRH will support the concept of this initiative in Monroe County and will explore ways to participate • If successfully initiated elsewhere, and if there is interest from providers within the RRH system, RRH will consider piloting the intervention • If successful, hospital will consider integrating the 2-question screening tool, and associated evidence based algorithm, into the EMR and linking patients electronically to resources • Hospital will support the process of quality improvement in identifying best practices and working towards process improvement by sending representation to a subgroup that will work on this initiative and champion the efforts within their health system

Opioid overdose prevention (RRH - RGH)

Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
Activities and resources the hospital will contribute: • Hospital will actively engage in the Opioid Prevention Task Force including having representation at the meetings • Hospital representatives will discuss he most effective use of Naloxone in the practice setting • Hospital will support the use of alternatives to opioid pain management when appropriate • Hospital will discuss sharing de-identified information about ED visits due to misuse of opioids

Unity Hospital (RRH)

Prevent Chronic Disease: Smoking Cessation (RRH - Unity)

Reduce Illness Disability and Death Related to Tobacco and Secondhand Smoke Exposure
• Hospital will adopt a tobacco cessation policy to include Opt-to-Quit™ • Hospital will develop EMR changes (in conjunction with EMR changes at Rochester General) to easily refer patients to the NYS Quitline with electronic transfer of information • Hospital will facilitate training to providers about Opt-to-Quit™ and will participate in a quality improvement process of the CHIW to increase number of patients referred to the NYS Quitline electronically
Reduce premature birth (through smoking cessation)
• Hospitals will support the Nurse Family Partnership, Baby Love, and Centering Pregnancy Programs in their efforts to work with Center for Tobacco Free Finger Lakes to develop a prescribed strategy for increasing cessation counseling to high-risk pregnant women • Hospitals will confirm that tobacco cessation is part of Centering Pregnancy curriculum and support this effort as appropriate

Heart Health Management and Prevention (RRH – Unity)

Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
• Hospital will work with the health department and the community to implement culturally competent health literacy and engagement programs centered around chronic disease prevention and management • Hospital will continue to provide patient information to the High Blood Pressure registry as requested through the High Blood Pressure Collaborative (HBPC) • Hospital will continue to actively participate in the High Blood Pressure Collaborative including sending representation to the meetings • Hospital will continue to support the recommendations of the Rochester Chamber of Commerce Health Care Planning Team on issues related to HTN control and will continue to support the recommended funding mechanism as appropriate for each hospital • Hospital will continue to support the Heart Advocates through the HAP as fully integrated members in their clinics as appropriate and able • Hospital will continue to support and expand where possible a quality improvement initiative to address HTN control, including the Practice Improvement Consultants program, especially in practices serving minority populations • Hospital will send representatives to the Diabetes Coalition in Monroe County in order to address the co-morbidity of HTN and Diabetes.
Reduce Congestive Heart Failure (CHF) re-admission rates by 4 percentage points within Rochester Regional Health
• RRH will launch a Steering Team to develop standard educational materials • RRH will work with Health Homes and Home Care Agencies to provide adequate disease management supports in the home • RRH will work with CBOs to connect patients to social service needs e.g. housing, transportation

Reduce Unplanned Pregnancy – RRH will not actively participate, but will instead concentrate on reducing preterm and low birth weight babies (RRH – Unity)

Reproductive, Preconception and Inter-Conception Health
RRH will • Improve prenatal care through Centering Group Prenatal Care • Continue to offer Centering Pregnancy prenatal Care • Use Centering Counts data collection to record outcomes for comparison of data and creation of city-wide report cards • Continue to decrease barriers to participation working to encourage employers to see benefits to their employees participating, seeking funding for drop in center for child care to allow mothers to participate, seeking funding for better utilization of transportation options in urban areas • Refer to post-natal Community Health Worker programs

Screen children for food insecurity (RRH – Unity)

Child Health
Activities and resources the hospital will contribute: • RRH will support the concept of this initiative in Monroe County and will explore ways to participate • If successfully initiated elsewhere, and if there is interest from providers within the RRH system, RRH will consider piloting the intervention • If successful, hospital will consider integrating the 2-question screening tool, and associated evidence based algorithm, into the EMR and linking patients electronically to resources • Hospital will support the process of quality improvement in identifying best practices and working towards process improvement by sending representation to a subgroup that will work on this initiative and champion the efforts within their health system

Opioid overdose prevention (RRH – Unity)

Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
Activities and resources the hospital will contribute: • Hospital will actively engage in the Opioid Prevention Task Force including having representation at the meetings • Hospital representatives will discuss he most effective use of Naloxone in the practice setting • Hospital will support the use of alternatives to opioid pain management when appropriate • Hospital will discuss sharing de-identified information about ED visits due to misuse of opioids

Monroe County Health Department

Smoking Cessation (MCDPH)

Reduce Illness Disability and Death Related to Tobacco Use and Secondhand Smoke Exposure
• Produce tobacco retailer maps (Used by SHAC to educate residents about the impact point-of-sale marketing in their communities • Provide educational sessions related to the NYS smokers Quitline to MCDPH program staff and explore how to improve collaboration and increase referrals to the Quitline (programs NFP, WIC, healthy neighborhoods, TB, Foster Care)
Reduce premature birth (through smoking cessation)
• Nurse Family Partnership will review their smoking cessation counseling process and refer tobacco dependent patients to NYS Quit line and Center for Tobacco Free Finger Lakes as appropriate

Heart Health Management and Prevention (MCDPH)

Increase Access to High Quality Chronic Disease Preventive Care and Management in Both Clinical and Community Settings
• Continue to co-chair the Diabetes Coalition • Assist the hospitals and community in developing culturally competent health literacy and engagement materials and programming centered around chronic disease prevention and management and ensure alignment with DSRIP activities • Ensure that health care providers and care managers are aware of and know how to refer to community based programs to prevent and manage chronic disease • Health department will continue to provide data when needed as appropriate around community based heart health morbidity and mortality

Reduce Unplanned Pregnancy (MCDPH)

Reproductive, Preconception and Inter-Conception Health
• Monitor and report on sexual risk behaviors among public high school students through the Monroe County Youth Risk Behavior Survey • Monitor and report on the percent of births that are the result of unplanned pregnancies through vital records data • Assist with identification of barriers to accessing LARC • Nurse Family Partnership Program – ensure clients receive counseling, guidance and support regarding pregnancy planning

Screen Children for Food Insecurity (MCDPH)

Child Health
Activities and resources the health department will contribute: • The Health department will work with the CHIW to help identify and organize helpful resources for those who are food insecure

Opioid Overdose Prevention (MCDPH)

Prevent Substance Abuse and Other Mental Emotional Behavioral Disorders
Activities and resources the health department will contribute: • Actively engage in the Monroe County Opioid Task Force • Annually share compiled data of the results of the Medical Examiner Report related to opioid deaths with the Monroe County Opioid Task Force • Monitor prescription drug use and heroin use among public high school students through the Youth Risk Behavior Survey

Needs identified in the CHNA that were not addressed in the Implementation Strategy

In order to determine which health needs to focus on and which needs to exclude in the 2016-2018 MC-CHIP, the Community Health Improvement Workgroup discussed the focus areas of the most importance within Monroe County that they felt the Hospitals would be able to influence.

Through these discussions, it was determined that the 2016-2018 MC-CHIP would not directly address the following issues:

- Increase screening for colorectal cancer
- Reduce violence by supporting violence prevention programs
- Decrease sexually transmitted disease

The group opted to postpone adding a component on colorectal cancer screening simply because they felt that doing so would only help a small subset of the Monroe County population in comparison to some of the larger scale health focus areas ultimately selected. In addition, the hospitals felt comfortable knowing that they are already somewhat addressing this need through the promotion of cancer screening(s) and the implementation of University of Rochester's Center for Community Health's Cancer Services Program.

In contrast, the CHIW felt that tackling the implementation of a violence prevention program with little to no funding and a three year time-frame felt inappropriate considering the weight of such an intervention. For this reason, the group ultimately decided that the 2016-2018 MC-CHIP would not address violence prevention

Additionally, hospital leaders felt they were not the best entity to address sexually transmitted diseases. However, they felt comfortable omitting this need from the 2016-2018 MC-CHIP knowing that Monroe County is already implementing several programs to address STDs. For example, the Monroe County Department of Public Health (MCDPH) STD/HIV Program does have a long history of providing services and collaborating with community partners to address this issue. MCDPH operates a Sexually Transmitted Disease Clinic, provides education and follow-up with persons diagnosed with STD's, partner notification services and delivers health care provider education and consultation.

MCPETE (Monroe County Partnering to End the Epidemic) is a community collaborative whose mission is to end the HIV/AIDS epidemic by 2020. The collaborative is developing county wide partnerships of HIV clinical and non-clinical service providers, consumers and networks: 1. Identify persons with HIV who remain undiagnosed and link them to health care; 2.Link and

retain persons diagnosed with HIV in health care to maximize virus suppression so they remain healthy and prevent further transmission; 3.Facilitate access to Pre-Exposure Prophylaxis (PrEP) for high-risk persons to keep them HIV negative. These objectives align with the New York State End the Epidemic (ETE) initiative.
http://www.health.ny.gov/diseases/aids/ending_the_epidemic/

Within the City of Rochester, several partners are implementing evidence based sexual health education (including prevention of sexually transmitted diseases) at various sites, including schools, recreation programs and community organizations. These activities align with the goal that is included in the Community Health Improvement Plan to decrease unplanned pregnancies.

Although not directly addressed, the following health needs will most likely be indirectly addressed as we implement the 2016-2018 MC-CHIP.

- Reduce obesity in children and adults – *By means of addressing food-insecurity in children*
- Reduce preterm births – *By means of addressing unplanned pregnancy and smoking during pregnancy*
- Prevent, reduce and address adverse childhood experience (ACES) – *By means of addressing food-insecurity in children*
- Prevent suicides – *By means of addressing opioid misuse prevention*

For additional details about this process, please reference the 2016-2018 CHNA and the section of this document titled 'Identification of Priority Area's'.

5. Description of Community Engagement Plan

As the CHIW progresses through the various stages of implementation, we will continue to meet monthly or bimonthly to discuss the on-going projects and the Center for Community Health is committed to providing the space and staff to plan and host these meetings.

Community Health Improvement Workgroup Meeting Schedule

2016

Jan	Feb	March	April	May	June
1/16	2/8	3/21	4/18	5/15	6/20
July	Aug	Sept	Oct	Nov	Dec
7/15	8/15	9/19	10/17	11/21	12/19

2017

Jan	Feb	March	April	May	June
1/23		3/20		5/15	
July	Aug	Sept	Oct	Nov	Dec
7/17		9/18		11/20	12/18

Additional project specific meetings TBD

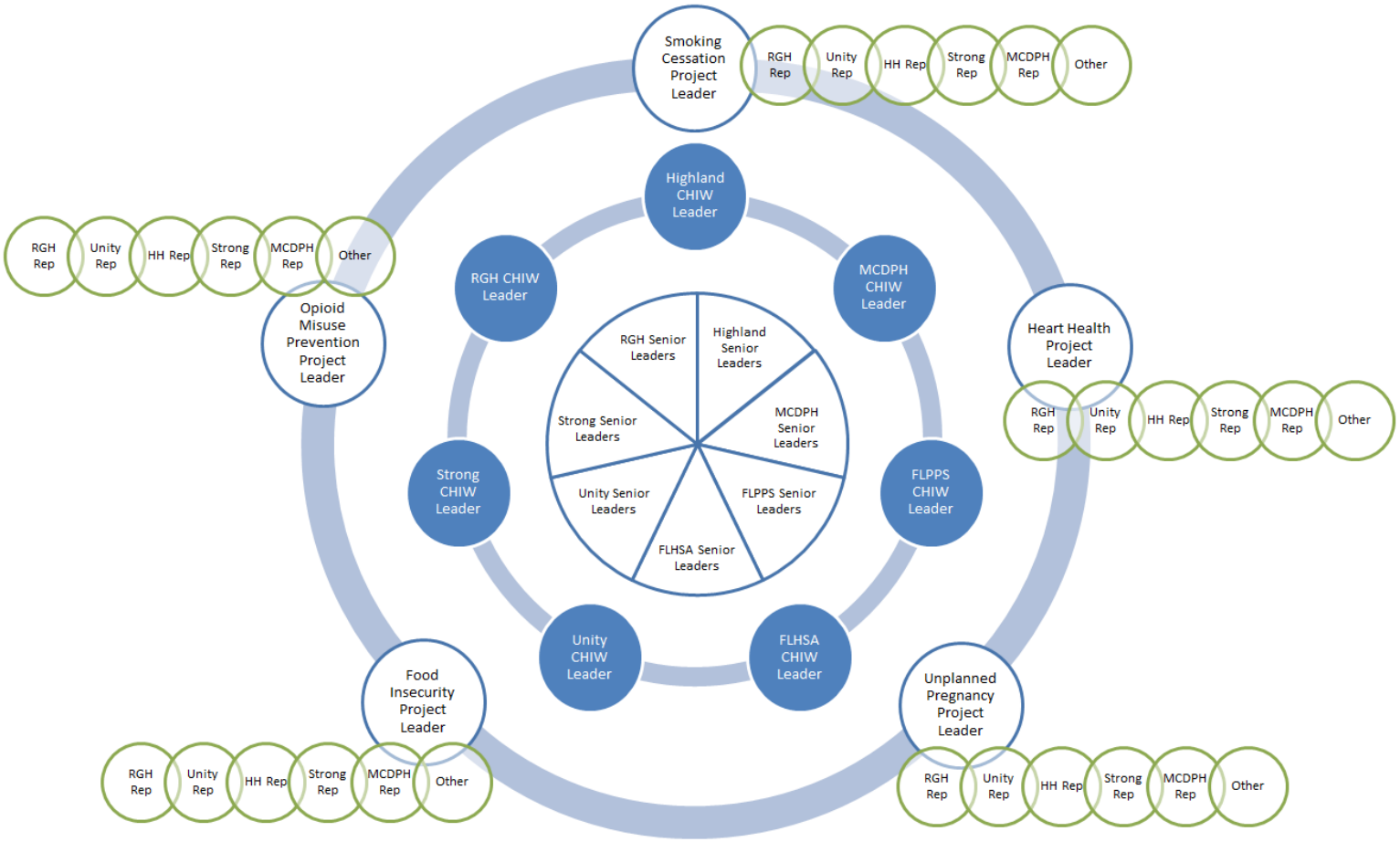
At these monthly and bimonthly meetings, the group as a whole is committed to continually tracking and evaluating the strength of their existing partnerships and then making changes accordingly over the course of the next 2 years. Members of the community and the partnership organizations are welcome to attend and share their opinions at these meetings in an effort to strive for transparency and continual improvement.

The organization charts on the following page area visual representation of structure of the Community Health Improvement Workgroup (CHIW). As the charts demonstrate, the CHIW is robust and comprised of dedicated leaders and champions who collectively bring many years of experience to the table. As the group continues to grow, it is anticipated that additional members will continue to contribute to our expertise.

Current and Active CHIW Members

Organization	Senior Leader	CHIW Leader
UR - Strong	Kathy Parrinello	Mardy Sandler
UR – Highland	Cindy Becker	Lisa Thompson
RRH – RGH	Bridgette Weifling	Alida Merril
RRH - Unity	Bridgette Weifling	Alida Merril
MCDPH	Mike Mendoza	Anne Kern Kathy Carelock
FLHSA	Wade Norwood	Catie Kunecki
FLPPS	Janet King	Kate Ebersol

Community Health Improvement Workgroup Reporting Structure



As we implement the 2016-2018 MC-CHIP, those identified as leaders and champions will be spending a great deal of time finding ways in which they can develop new partnerships within the community. Noted below are the organizations and/or community projects which the CHIW plans to engage with over the course of the 2016-2018 MC-CHIP.

Community Partner Ties per Focus Area

To be developed and/or strengthened

Focus 1 **Smoking Cessation**	NYS Quitline (Roswell Cancer Center) Rochester Psychiatric Center Center for a Tobacco Free Finger Lakes Local FQHC's (Anthony Jordan and Oak Orchard) SHAC – Smoking and Health Action Coalition Baby Love Nurse Family Partnership
Focus 2 **Heart Health Management**	High Blood Pressure Collaborative Greater Rochester Chamber of Commerce YMCA – Diabetes Prevention Program Diabetes coalition (and organizations involved)
Focus 3 **Reduce Unplanned Pregnancy**	Family Talk City of Rochester Metro Council for Teen Potential The Healthy Baby Network DSRIP ties to NFP and Baby Love
Focus 4 **Screen for Food Insecurity**	Foodlink Summer meals/WIC, SNAP, Nutrition Education and Outreach Program FLPPS HealthiKids City of Rochester Community Gardens Cornell Extension
Focus 5 **Opioid Misuse Prevention**	DSRIP Project 4.a.iii Monroe County Opioid Prevention Task Force (and the organizations involved with the Task Force)

6. Public Notification

All of the health systems in Monroe County are fortunate to be governed by boards made up of community representatives who volunteer their time and expertise. This Plan is shared with our board members and they are encouraging of this cooperative effort. In addition, we will be posting this plan on our websites and submitting copies to the Healthcare Association of New York State. Also, members of the Monroe County Community Health Improvement Workgroup will disseminate the report to the community members with which they interact, including the Community Advisory Council to the University of Rochester Medical Center.

2016 Hospital Websites posting the Monroe County Community Health Improvement Plan include the following:

Rochester Regional Health System (RGH/Unity)
https://www.rochesterregional.org/about/facts-and-statistics/#community

University of Rochester Medical Center (Strong/Highland):
http://www.urmc.rochester.edu/community-engagement/
https://www.urmc.rochester.edu/highland/about-us.aspx

Monroe County Department of Public Health (MCDPH)
http://www2.monroecounty.gov/health-index.php

Finger Lakes Health Systems Agency (FLHSA)
https://www.flhsa.